PUBLIC RECORD

Dates: 03/03/2026 – 23/03/2026; 02/07/2026

Doctor:	Dr Jonathan PETERS
GMC reference number:	7420330
Primary medical qualification:	BM BS 2013 University of Nottingham

Type of case	Outcome on facts	Outcome on impairment
New - Misconduct	Facts relevant to impairment found proved	Not Impaired

Summary of outcome

No warning

Tribunal:

Legally Qualified Chair	Mr Gerry Wareham
Lay Tribunal Member:	Mrs Amanda Webster
Registrant Tribunal Member:	Dr Sarah Woodford

Tribunal Clerk:	Mrs Olivia Gamble (03/03/2026 – 04/03/2026; 09/03/2026; 11/03/2026; 16/03/2026 - 17/03/2026) Mrs Rachel Horkin (05/03/2026 AM; 20/03/2026; 02/07/2026) Ms Ciara Fogarty (05/03/2026 PM) Ms Jemine Pemu (12/03/2026 - 13/03/2026)

Attendance and Representation:

Doctor:	Present, represented
Doctor's Representative:	Mr Mark Sutton, KC, instructed by the MDU
GMC Representative:	Mr Nigel Grundy, Counsel

Attendance of Press / Public

In accordance with Rule 41 of the General Medical Council (Fitness to Practise) Rules 2004 the hearing was held in public.

Protecting the Public

Throughout the decision making process the tribunal has borne in mind the statutory duty as set out in s1(1) of the Medical Act 1983 (the 1983 Act) to protect the public. The tribunal has considered the relevance and impact on each of the three distinct parts of public protection to protect, promote and maintain the health, safety and well-being of the public, to promote and maintain public confidence in the medical profession, and to promote and maintain proper professional standards and conduct for members of that profession.

Determination on Facts - 20/03/2026

Background

1. Dr Peters qualified with BMBS BMedSci Hons in 2013 from University of Nottingham. He completed his foundation training with Trent Deanery, having undertaken rotations in Mansfield and Derby. Following this, he completed his Core Surgical Training in Brighton, before spending six months working in an accident and emergency unit in Melbourne, Australia between 2017-2018. Dr Peters returned to the United Kingdom in late 2018 to begin specialist training in Trauma and Orthopaedics (T&O), having been accepted on to the North, Central and East London Trauma and Orthopaedics training programme, on the Stanmore rotation. Dr Peters is currently in his ST8 Ext year at Watford General Hospital, West Hertfordshire. He began this post on 30 October 2025 and is due to complete training and therefore receive his certificate of completion of training (CCT) in October 2026.

2. It is alleged that in advance of his Annual Review of Competency Progression Panel ('ARCP') on 24 May 2023, Dr Peters completed and submitted his surgical training logbook, in which he had incorrectly recorded his role and involvement in multiple surgical procedures, at times by creating new patient numbers. It is alleged that Dr Peters knew that his logbook would give the impression that he had performed more procedures and gained more surgical experience than he had and that accordingly, his actions were dishonest.

3. The initial concerns were raised by Ms A, the Training Programme Director for North Central London Trauma and Orthopaedics Rotation for the Intercollegiate Surgical Curriculum Programme ('ISCP') when ahead of the ARCP meeting, scheduled for 24 May 2023, Ms A decided to conduct a preliminary review of the logbooks of the trainees in the paediatric department to assess their exposure in terms of surgical competency.

4. Ms A observed that Dr Peters had recorded that he had carried out several surgical procedures as primary surgeon, which she knew that he had not done. Ms A contacted Mr B, Consultant Orthopaedic Foot and Ankle Surgeon and ARCP panel member and asked if ahead of the ARCP meeting he could review the summary sheets of Dr Peters' logbook from his experience in the foot and ankle department.

5. Mr B also noticed inconsistencies in Dr Peters' logbook and therefore, Ms A contacted Dr Peters and requested that he submit his logbook in its entirety for his Royal National Orthopaedic Hospital ('RNOH') foot and ankle and RNOH paediatric placements. On review, multiple concerns were revealed to Ms A and Mr B. Namely, that Dr Peters had 'unbundled' several cases, that is that he had incorrectly logged different parts of the same operation as separate procedures entirely, had input altered hospital numbers against these procedures, had entered codes for some of the surgical procedure which incorrectly recorded his level of involvement and had also recorded his participation against cases where he had not been involved at all.

6. Following the concerns raised, the NHSE Postgraduate Dean commissioned an investigation be undertaken of Dr Peters' logbook. There was then a formal investigation and, subsequently, Dr Peters was referred to the GMC.

The Outcome of Applications made during the Facts Stage

7. This is a virtual hearing. However, at the outset of the hearing, it was agreed by all parties and the Tribunal, that Dr Peters could give his oral evidence live at the MPTS hearing centre. This evidence was provided on 12 – 13 March 2026.

8. On 3 March 2026, the Tribunal granted the GMC's application, made pursuant to Rule 17(6) of the GMC (Fitness to Practise Rules) 2004 as amended ('the Rules'), for the Allegation to be amended slightly due to an incorrect date in paragraph 2. This application was unopposed by the defence.

9. Following the conclusion of the evidence of Mr C the Tribunal raised concerns as regards the volume of individual allegations contained within Schedule 2 of the Allegation. After consultation between the parties an amended schedule was prepared and presented to the Tribunal. In the amended schedule the number of instances alleged as regards Paragraphs 2(a) and (b) was reduced to some 173, which were more helpfully grouped by reference to the 40 individual operations from which they arose. This amendment was not opposed and was allowed by the Tribunal.

The Allegation and the Doctor's Response

10. The Allegation made against Dr Peters is as follows:

That being registered under the Medical Act 1983 (as amended):

1. On 18 May 2021, you were given a Warning by the GMC as set out in Schedule 1 which was active until 18 May 2022. Admitted and found proved

2. In advance of your Annual Review of Competency Progression Panel ('ARCP') on 24 May 2023 (amended under Rule 17(6)), you completed and submitted your surgical training logbook ('logbook') and on one or more occasion in your logbook, as set out in Schedule 2 you:

    a. falsely recorded your role as Supervised - trainer scrubbed ('S-TS') in one or more surgical procedures ('procedures'); To be determined

    b. fabricated hospital numbers to record procedures that:

        i. you had split up into single constituent parts from an operation involving a single patient ('unbundled'); To be determined

        ii. had not been performed on patients with the hospital numbers you recorded; To be determined

    c. falsely recorded your involvement in procedures which you had not been involved in. To be determined

3. You knew that:

    a. you were required to keep an accurate logbook; Admitted and found proved

    b. the information included your logbook was untrue as you:

        i. were not the primary surgeon for the procedures set out in paragraph 2a, having not performed the key components of the procedures; To be determined

        ii. had fabricated hospital numbers as set out in paragraph 2b; To be determined

    c. you had not been involved in the procedures recorded as set out in paragraph 2c; To be determined

    d. your logbook would give the false impression that you had performed more procedures and gained more surgical experience than you had. To be determined

4. Your conduct at paragraph 2a was dishonest by reason of paragraph 3a, 3bi and 3d. To be determined

5. Your conduct at paragraph 2b was dishonest by reason of paragraph 3a, 3bii and 3d. To be determined

6. Your conduct at paragraph 2c was dishonest by reason of paragraph 3a, 3c and 3d. To be determined

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct. To be determined

The Admitted Facts

11. At the outset of these proceedings, through his Counsel, Mr Sutton KC, Dr Peters made admissions to some paragraphs and sub-paragraphs of the Allegation, as set out above, in accordance with Rule 17(2)(d) of the 'the Rules'. In accordance with Rule 17(2)(e) of the Rules, the Tribunal announced these paragraphs and sub-paragraphs of the Allegation as admitted and found proved.

Witness Evidence

12. The Tribunal received oral evidence on behalf of the GMC from the following witnesses:

- Mr C – Children's Orthopaedic Surgeon at Royal National Orthopaedic Hospital NHS Trust, Stanmore Hospital;
- Mr B – Consultant Orthopaedic Foot and Ankle Surgeon at Royal National Orthopaedic Hospital NHS Trust, Stanmore Hospital;
- Ms A – Training Programme Director for North Central London Trauma and Orthopaedics Rotation for the Intercollegiate Surgical Curriculum Programme ('ISCP') and Paediatric Trauma and Orthopaedic Surgeon at Royal National Orthopaedic Hospital NHS Trust, Stanmore Hospital;
- Dr D – Postgraduate Dean for London.

13. Dr Peters provided his own witness statement and gave oral evidence at the hearing.

Documentary Evidence

14. The Tribunal had regard to the documentary evidence provided by the parties. This evidence included, but was not limited to, the following:

- Witness statements of Dr Peters – various dates;
- Witness statements of Mr B – dated 20 March 2024 and 14 February 2025;

- Witness statements of Ms A – dated 24 April 2024 and 16 April 2025;
- Witness statement of Dr D – dated 17 February 2025;
- Witness statement of Mr C – dated 17 February 2025;
- Dr Peters' response to the allegations – various documents;
- GMC Warning outcome letter – dated 20 May 2021;
- Intercollegiate Surgical Curriculum Programme ('ISCP') Trauma & Orthopaedic Surgery Curriculum – dated 4 August 2021;
- ISCP Logbook Guidance;
- Dr Peters logbook documents and related evidence;
- Correspondence between Mr B and Ms A regarding audit;
- Ms A's summary of concerns arising from her review;
- NHSE Investigation Meeting notes with Mr B, Mr C and Ms A;
- Dr D's investigation report and Appendices;
- Dr Peters' surgical lists;
- Operation notes;
- Relevant articles.

Legal Qualified Chair's Advice

15. In reaching its decision on facts, the Tribunal bear in mind that the burden of proof rests on the GMC and it is for the GMC to prove the Allegation - Dr Peters does not need to prove anything. The standard of proof applied is that applicable to civil proceedings, namely the balance of probabilities, i.e. whether it is more likely than not that the events occurred. The Tribunal would also bear in mind although the burden of proof remains unchanged, the Tribunal should remain aware that the more serious the allegation, the less likely it may be that it occurred and the need for cogent evidence before a finding such as dishonesty should be made (Sharma v GMC [2014] EWHC).

16. The Tribunal remind itself that it must form its own judgment about the witness evidence it heard and the credibility and reliability of each witness. In assessing a witness's credibility, the Tribunal reminds itself that it should not assess witness credibility exclusively on the demeanour of the witness when giving their evidence, but their veracity should be tested by reference to objective facts proved independently in their evidence, in particular by reference to the documents in the case. The Tribunal should make a rounded assessment of a witness's reliability, rather than approaching their reliability in respect of each charge in isolation from the others: *R (on the application of Dutta) v GMC* [2020] EWHC 1974 (Admin).

17. It is open to the Tribunal not to rule out the whole of a witness's evidence based on credibility; credibility could be divisible: *Khan v The General Medical Council* [2021] EWHC 374 (Admin).

18. In relation to witnesses generally, the Tribunal bear in mind that an honest witness could be mistaken, and a mistaken witness was not necessarily wrong about every fact.

19. As to individual pieces of evidence, the Tribunal is entitled to draw proper inferences - to come to common sense conclusions based upon the evidence which it accepted as reliable; but it must not speculate. Similarly, the Tribunal should not speculate about what other evidence there might have been. The Tribunal should only draw an inference if it could safely exclude other possibilities*: Soni v GMC* [2015] EWAC 0364 Admin.

20. The Tribunal has regard to the Supreme Court judgment in the case of Ivey v Genting Casinos (UK) Limited [2017] UKSC 67, in which Lord Hughes set out the correct test for dishonesty, which is as follows:

> *'When dishonesty is in question the fact-finding tribunal must first ascertain (subjectively) the actual state of the individual's knowledge or belief as to the facts. The reasonableness or otherwise of his belief is a matter of evidence (often in practice determinative) going to whether he held the belief, but it is not an additional requirement that his belief must be reasonable; the question is whether it is genuinely held. When once his actual state of mind as to knowledge or belief as to facts is established, the question whether his conduct was honest or dishonest is to be determined by the fact-finder by applying the (objective) standards of ordinary decent people. There is no requirement that the defendant must appreciate that what he has done is, by those standards, dishonest.'*

21. The papers before the Tribunal contain evidence that has not been given orally during these proceedings. Hearsay evidence is admissible in these proceedings but the Tribunal must consider the weight, if any, to assign such evidence. When considering hearsay evidence, the Tribunal must consider the extent to which the evidence is agreed or disputed. The source of the evidence should be identified and the Tribunal should consider whether the witness was independent or may have had a purpose of their own or another to serve. The Tribunal must also consider the reliability of the evidence and should identify any mistakes or inconsistences found in it. There has been no opportunity to see the sources of disputed hearsay evidence tested under cross-examination, for example as to accuracy, truthfulness, ambiguity or misperception, and how the witnesses would have responded to this process. It may be that a witness has not addressed an issue in their written accounts that they may have been questioned about at this hearing.

22. The Tribunal would have to consider the effect of the warning as referenced in Paragraph 1 of the Allegation and accepted by Dr Peters, and whether and to what extent it considered him to be of 'good character'. The Doctor's previous good character if established must be taken into account by the Tribunal when assessing his credibility and the likelihood of him having done what has been alleged. His good character cannot be a defence to the Allegation, it is simply one factor to take into account when considering all of the evidence in the round. The weight to assign Dr Peters' good character is a matter for the Tribunal to determine, taking into account all the evidence presented and all it has heard. The Tribunal may decide that good character evidence supports a practitioner's credibility, and so is something which the Tribunal should take into account when deciding whether they believe

his evidence (the 'credibility limb'); and the good character evidence may mean that he is less likely to have acted as alleged (the 'propensity limb').

The Tribunal's Approach

23. The Tribunal discussed how to approach its task of determining the facts. The Allegation, as amended, was complex, and Schedule 2 remained voluminous, comprising some 173 individual instances for paragraph 2(a) and 2(b) of the Allegation, covering 40 separate 'operations'. The evidence relevant to each of these operations was contained in diverse parts of the statements and exhibits. The Tribunal had been given some assistance by GMC and the Doctor's representatives in directing them to these documents for each of the 40 operations. However, there was also reference to many, but by no means all of them, in the oral testimony heard before the Tribunal.

24. The first stage of the facts determination required the Tribunal to decide whether paragraph 2 of the Allegation was proved. Dr Peters had admitted submitting his logbook, but all other elements of that paragraph remained to be determined. The GMC conceded in submissions that the terms '*falsely*' and '*fabricated*' should be read as alleging only that the relevant entries were incorrect or wrong, and were not meant to convey any intent.

25. The Tribunal was required to determine whether the incorrect entries as alleged occurred on '*one or more*' occasions. It could see no way to determine this without considering the instances alleged individually, albeit clustering them by reference to the operations to which each was connected. To seek to ensure that it considered all the relevant oral testimony it had heard for each of these, it decided to first consider instances which had been specifically put to Dr Peters in cross examination. It could then also use the aids referred to above to ensure it also referenced the associated documentary evidence within statements and exhibits.

26. Before commencing this exercise, the Tribunal reminded itself of the evidence it had heard regarding these sources of information available to it. On the basis of that evidence the Tribunal reached some general conclusions on the balance of probabilities which were relevant to its task. These included:

a. That the operation note although informative was not an infallible record and the entries on that note were not made with the 'logbook' in mind;
b. The logbook was primarily a document compiled for the purposes of recording the Doctor's involvement in cases to reflect his level of experience and development and was not a hospital or patient record.
c. The Tribunal noted that the terms 'primary', 'lead' or 'first surgeon' appeared to be used interchangeably and Dr Peters accepted in his oral evidence that they conveyed the same meaning.

27. The Tribunal was required to determine whether the instances cited in Schedule 2 as examples of wrong coding of 'S T-S' were in fact wrong. The Tribunal had been referred to

differing definitions or guidance as to when this coding was appropriate. However, it noted that within the body of paragraph 3 of the Allegation it stated that the criteria for determining whether Dr Peters had honestly recorded S T-S as the code was whether he knew he was

> *'not the primary surgeon for the procedures set out in paragraph 2a, having not performed the key components of the procedures'*

The Tribunal determined that for reasons of fairness and consistency that would also be the appropriate test for it to apply at this stage of its fact-finding exercise.

28. The Tribunal had the assistance in many instances of the opinions of witnesses with experience in this matter and had access to guidance, although no 'expert' was called. However it was aware of its limitations as non-experts in this matter and accordingly took care to ensure it only found that the burden on the GMC of establishing that an alleged instance of incorrect recording had been satisfied where there was clear evidence available to it, and it was not merely substituting its own assessment of what should have been recorded for that entered by the doctor.

29. As regards paragraph 2(b)ii of the Allegation, '*had not been performed on patients with the hospital numbers you recorded*', the Tribunal considered the wording carefully and determined that it could only be read to convey that the unique identification number recorded in the logbook was incorrect, and whether there were or were not patients associated to the incorrect number was irrelevant.

30. The Tribunal then went on to consider individual instances within Schedule 2 as set out above.

The Tribunal's Analysis of the Evidence and Findings

31. The Tribunal has considered each outstanding paragraph of the Allegation separately and has evaluated the evidence to make its findings on the facts.

Operation 9 – 24 August 2022

32. In relation to operation 9, the Tribunal had to consider paragraph 2a of the Allegation.

33. The Tribunal considered Dr Peters' response in relation to this operation:

> *'I have recorded my role as STS because that is what I believe I was for this component part of the procedure. My understanding at the time was that STS signified involvement more than assisting. I believed this reflected the role I played.'*

34. The Tribunal noted that Dr Peters had signed the operation note which showed him as assistant, though it also noted his submission that the operation note had a very different

purpose to that of the logbook. It was put to Dr Peters in cross examination that he would not have been 'first surgeon' in the operation. He agreed though he stated that in his view he would have done more than merely assist, which was the test he was applying at that time and was why he recorded himself as Supervised – Trainer Scrubbed ('S-TS'). The Tribunal was referred to the definition for 'first surgeon' in the ISCP logbook, but Dr Peters stated that he was never aware of this guidance.

35. Accordingly, the Tribunal found paragraph 2a proved in relation to as regards operation 9, number 71 as set out in Schedule 2.

Operation 11 – 2 September 2022

36. In relation to operation 11, the Tribunal had to consider paragraph 2a and 2b of the Allegation for particulars 83 – 93 of Schedule 2 and just 2a for particular 82 of the Schedule.

37. In relation to paragraph 2a of the Allegation, Dr Peters says in his response:

> *'On reviewing this case I accept that my role was Assistant. I recorded STS as a genuine error.'*

38. The Tribunal therefore found paragraph 2a proved in relation to number 82 – 93 of Schedule 2.

39. In relation to paragraph 2b of the Allegation, the Tribunal considered Dr Peters' response:

> *'I accept I changed the last digit of the patient's hospital number in these entries. I found that I needed to make an amendment to the patient's details, in order to log each individual component part of the procedure in my logbook, and to ensure that the individual procedures were registered on the electronic system. I needed to fulfil certain criteria, and I thought it was the procedures that were the critical component, not the patient number.'*

40. The Tribunal took the view that on Dr Peters' own evidence he admits changing the patient's hospital number in these entries. The Tribunal noted Dr Peters' claim that his actions were based upon a misunderstanding of the requirements, however, it was satisfied that as regards paragraph 2b of the Allegation particulars 83-93 of the schedule were proved.

Operations 3 – 4 May 2022

41. In relation to operation 3, the Tribunal had to consider paragraph 2b of the Allegation for particular 24 of Schedule 2 and paragraph 2a for particular 25 of the Schedule.

42. In consideration of particular 24 of the Schedule and paragraph 2b of the Allegation, the Tribunal noted Dr Peters' response:

'I accept that I changed the last digit of the patient's hospital number in order to make this entry. I found that I needed to make an amendment to the patient's details, in order to record each individual component part of the procedure in my logbook, and to ensure that the individual procedures were registered on the electronic system. I needed to fulfil certain criteria and I thought it was the procedures that were the critical component, not the patient number.'

43. Accordingly, the Tribunal found this proved.

44. In consideration of particular 25 of the Schedule and paragraph 2a of the Allegation, the Tribunal noted Dr Peters' response:

'I have recorded my role as STS for the component part recorded in this entry. My understanding at the time was that STS signified any involvement more than assisting. I believed this was an accurate reflection of my involvement.'

45. The Tribunal considered that there was little evidence to determine Dr Peters' precise involvement in operation 3 as set out in Schedule 2, though it did have the operation note which showed him as assistant, and which he had signed. In oral evidence Dr Peters confirmed that his only role was to remove a screw. The Tribunal considered that, in light of his conceded limited involvement, on the balance of probabilities it was satisfied that he was not S-TS during this operation in accordance with the correct guidelines. It therefore found paragraph 2a of the Allegation proved in relation to particular 25 of Schedule 2.

Operation 4 – 11 May 2022

46. In relation to operation 4 as set out in Schedule 2, the Tribunal was required to determine paragraph 2a of the Allegation in respect of particulars 29 and 30 of the Schedule.

47. The Tribunal noted Dr Peters' response in respect of this:

'I have recorded my role as STS for the component parts recorded in each respective entry. My understanding at the time was STS signified any involvement more than assisting and I believed that this accurately reflected my involvement.'

48. The Tribunal considered that in respect of particular 30 of the Schedule, 2a of the Allegation was proved. Dr Peters acknowledged in his oral evidence that he wrote and signed the operation note listing himself as the assistant. Dr Peters indicated that he thought at the time that it was acceptable to write S-TS but he understands now that this was incorrect.

49. In respect of particular 29 of Schedule 2, the Tribunal took the view that there is conflicting evidence in relation to this point. The Tribunal heard evidence from Mr C with regard to EUA (Examination Under Anaesthetic) that it may have been legitimate to record as a procedure within the logbook. The Tribunal was also told that it was available as an option

on the dropdown menu of the logbook. For these reasons, without evidence particular to this operation, the Tribunal could not find it proved.

Operation 5 – 1 June 2022

50. In relation to operation 5, the Tribunal was required to determine paragraphs 2a and 2b of the Allegation in relation to particulars 42 and 43 and paragraph 2a in relation to particular 44 of Schedule 2.

51. The Tribunal considered Dr Peters' response in relation to paragraph 2a of the Allegation regarding particulars 42 – 44 of Schedule 2:

> *'I have recorded my role as STS for the component parts recorded in each respective entry. My understanding at the time was that STS signified involvement more than assisting. I believe this most accurately reflected my involvement.'*

52. The Tribunal had the written operation note whereby Dr Peters listed himself as an assistant. He admitted in oral evidence that he was not the primary surgeon on this occasion, though he did say there were component parts of the operation that he could have performed but he could not remember or say for certain which parts he had completed. Therefore, the Tribunal found paragraph 2a of the Allegation proved in respect of particulars 42 – 44 of Schedule 2.

53. In relation to paragraph 2b of the Allegation, the Tribunal noted Dr Peters' response:

> *'I accept that I changed the last digit of the patient's hospital number in order to make these entries. I found that I needed to make an amendment to the patient's details, in order to log each individual component part of the procedure in my logbook, and to ensure that the individual procedures were registered on the electronic system. I thought it was the procedures that were the critical component, not the patient number.'*

54. The Tribunal took Dr Peters' words above as an admission to paragraph 2b of the Allegation in respect of particulars 42 and 43 of Schedule 2. It therefore found them proved.

Operation 7 – 13 July 2022

55. In relation to operation 7, the Tribunal was required to determine particulars 57, 58 and 60 of Schedule 2 in relation to paragraphs 2a and 2b of the Allegation. For particular 59 of Schedule 2, the Tribunal was only required to determine paragraph 2a of the Allegation.

56. The Tribunal noted that Dr Peters accepts paragraph 2b in relation to particulars 57, 58 and 60 of Schedule 2 and therefore found them proved in this respect.

57. In relation to paragraph 2a of the Allegation, the Tribunal noted Dr Peters' response:

'I accept that the operation note does not record my name as one of the surgeons. However, I wrote the operation note and so must have been present. I can only speculate that I am not named as a surgeon for one the following reasons:

i. I was involved in the operation, but forgot to include my name in the list of surgeons; or

ii. I was not in fact involved in the operation, but agreed to write the note to help out the Consultant or Fellow. I either:

a. Prospectively drafted the case in the eLogbook app (as I anticipated I would be taking part in the case), and forgot to go back and amend it after the procedure had taken place; or

b. accidently created the note retrospectively, having forgotten that I did not take part.'

58. The Tribunal considered that the evidence it had was unclear and mixed on this point and it could not be satisfied what role if any Dr Peters played in these procedures. It noted that they were injections, and Dr Peters assertion that he may have been involved, and if he did he would have held himself to have done more than assist, by the criteria he was applying at that time. The Tribunal determined that the GMC had not presented sufficient evidence to discharge its burden of proof for it to conclude that paragraph 2a of the Allegation proved in relation to those elements of Schedule 2 which relate to operation 7 as set out above.

Operation 2 – 20 April 2022

59. In relation to operation 2, the Tribunal was required to determine paragraph 2a of the Allegation for particulars 17 and 18 and paragraph 2b for particular 18 only.

60. Dr Peters accepted amending the patient number for part of this entry, therefore paragraph 2b is proved in regard to particular 18.

61. Dr Peters is shown on the operation note as assistant below one other surgeon who also assisted. Dr Peters insisted that he made the entries he did because he felt he had done more than assist which was the test he was applying at the time. Bearing in mind the number of surgeons involved and how his role is described in the operation note, and the fact that he cannot positively assert a more significant role, the Tribunal found on the balance of probabilities that against the appropriate criteria, his role was not S-TS.

Operation 16 – 12 October 2022

62. In relation to operation 16, the Tribunal was required to determine paragraph 2a of the Allegation.

63. The Tribunal considered the evidence it had heard and read. Dr Peters asserted that his role in this operation amounted to more than just assisting. Ms A as the responsible consultant provided oral evidence, which was strongly to the contrary, asserting that this was a 'Ponseti' case, and that she never allowed her trainees to do this procedure, he had assisted only. In her oral evidence Ms A said that Dr Peters may have "held a knee" or "put a steri-strip over the wound" but this was the extent of his contribution. The Tribunal noted Dr Peters' claim that the child was under general anaesthetic which made his limited participation more likely, and that he was applying a different test, at that time, as to assessing his level of involvement. Nevertheless, the Tribunal concluded that given the circumstances as related by Ms A, it is extremely unlikely that the role Dr Peters played here objectively amounted to S-TS. The Tribunal considered that Dr Peters may have actively assisted to some degree, however, it determined that he did not perform any key component of this procedure and therefore found paragraph 2a of the Allegation proved in relation to operation 16.

Operation 15 – 12 October 2022

64. In relation to operation 15, the Tribunal was required to determine paragraph 2a of the Allegation.

65. The Tribunal noted the clear evidence of Ms A in relation to this operation that Dr Peters' input would certainly not amount to the undertaking of 'key components' or primary surgeon. Ms A stated that she did the operation herself, he did not perform the osteotomy, and she recorded him as assistant in the operation note. She noted that this was the first week he was working in paediatric surgery at Stanmore, and he would not have done any primary surgeon operating in his first week. Dr Peters did not accept he 'did no surgery' but could not be specific as to what it may have entailed.

66. The Tribunal found paragraph 2a of the Allegation proved in relation to operation 15 as set out in the Schedule.

Operation 22.2 and 22.1 – 9 November 2022

67. In relation to operation 22.2, the Tribunal was required to determine just paragraph 2a of the Allegation for particulars 190 and 191. For Operation 22.1 paragraph 2a for particular 189 of Schedule 2 and paragraphs 2a and 2b of the Allegation for particular 191 of the Schedule.

68. As regards operation 22.2, particular 190 and 191, the Tribunal reminded itself that there was significant confusion regarding the records and the evidence was not sufficiently established or clear for this operation. Dr Peters' evidence was that he had accidently recorded the hospital number incorrectly with two digits transposed. He recalled that there were two separate operations on this child XXX. This did seem to be supported by the dates and operation notes within the evidence. He believed the evidence of Ms A was based on his

incorrect reference which referred to another patient whom he had not been involved with. In all the circumstances the Tribunal did not find that the burden was discharged and this matter was not proved.

69. Dr Peters acknowledge that he created an incorrect patient number for particular 191 and accordingly this matter is found proved.

70. In regard to operation 22.1, particular 189 in Schedule 2, Ms A stated in her witness statement that, this was a big operation on her list and whilst Dr Peters assisted in this operation, he did not do sufficient to warrant recording his involvement as S-TS.

71. Dr Peters was not sure what role he played in the operation but insisted that he did more than assist, which was the criterion that he was applying at the time. Therefore, in regard to 22.1 particular 189 are found proved as regards paragraph 2a.

Operation 25 – 24 November 2022

72. In relation to operation 25, the Tribunal was required to determine paragraphs 2a and 2b of the Allegation for particulars 215 and 216 of Schedule 2.

73. The Tribunal had regard to Dr Peters' response in relation to paragraph 2a of the Allegation:

> *'I have recorded my role as STS for the component parts recorded in each respective entry. My understanding at the time was that STS signified any involvement more than assisting. I believed STS reflected the role I played.'*

74. The Tribunal noted that it was a very complex surgery with three more senior surgeons listed before Dr Peters on the operation note and this was the index case that generated further scrutiny from Ms A. Given the evidence it has before it, the Tribunal took the view that Dr Peters' input into operation 25, did not amount to performing the key components of the procedures. It therefore found paragraph 2a, in relation to operation 25 proved.

75. The Tribunal had regard to Dr Peters' response in relation to paragraph 2b of the Allegation:

> *'I accept that I changed the last digit of the patient's hospital number. I found that I needed to make an amendment to the patient's details, in order to log each individual component part of the procedure in my logbook, and to ensure that the individual procedures were registered on the electronic system. I needed to fulfil certain criteria, and I thought it was the procedures that were the critical component, not the patient number.'*

76. Dr Peters accepts paragraph 2b of the Allegation in respect of operation 25. Therefore, the Tribunal found it proved in this regard.

Operation 21 - 01 November 2022

77. This involved the recording by Dr Peters of S-TS involvement in 4 injections, 181, 182, 183, and 185 of Schedule 2, and an EUA, 184, all on the same patient. Dr Peters accepts he altered the patient number for all the injections, and therefore the Tribunal find Paragraph 2b proved in regard to each of the four matters. Paragraph 2a is also alleged against all five recorded.

78. The Tribunal heard conflicting evidence as regards whether it could ever be acceptable to record EUA as a 'procedure' in the logbook. In this instance it had no specific evidence as to what it involved, and therefore find 2a not proved as regards 184.

79. In relation to the injections Ms A stated in her evidence that Dr Peters would not have administered them as he was new to the department and would not have experience. Dr Peters referred the Tribunal to an instance some two weeks earlier on the 18 October when he was the surgeon for a similar list of five patients. On this date Ms A's evidence was that Dr Peters would probably have done some of these injections. In the circumstances the Tribunal was not of the view that paragraph 2a was proved as regards the injections.

Operation 30 – 30 December 2022

80. In relation to operation 30, the Tribunal was required to determine paragraphs 2a and 2b of the Allegation regarding number 268 on Schedule 2.

81. The Tribunal noted that Dr Peters had no recollection of this particular operation or his involvement.

82. In both her witness statement and cross examination, Ms A stated that Dr Peters was not involved in this procedure as lead surgeon and would only have assisted. Dr Peters accepted that the operation note does not include his name but stated there may be various reasons for this.

83. The Tribunal determined not to place over reliance on the operation notes as they have been shown to be incomplete at times. However, the Tribunal was satisfied that, on the balance of probabilities, it would be reasonable to assume that the primary surgeon or the surgeon who completed key components of the procedure would not be left off the note entirely. The Tribunal noted that three other surgeons were listed. Accordingly, the Tribunal found paragraph 2a proved in relation to number 268 on Schedule 2.

2c allegations

84. The principal evidence that the Tribunal was supplied with as regarding the majority of the 2c allegations was the lack of reference to Dr Peters in the operation note. (The Tribunal noted that, on one occasion, particular 132 on Schedule 2 which took place on 13 October 2022 Dr Peters was in fact listed as present). The Tribunal was made aware during the course of the hearing that there were other official records which may have assisted in ascertaining more precisely who was present at each procedure. None of this potential evidence was made available to the Tribunal. For this reason, the Tribunal was not satisfied to the required level that it was established that Dr Peters was not present for particulars 21, 110, 111, 160, 169 and 170. Therefore, these matters are found not proved.

85. The Tribunal could make a distinction as regards the operations on 9 March 2023. In his witness statement and under cross examination, Dr Peters fully accepted that he was XXX and absent from work on that date. Dr Peters offered an explanation that the mis-recording may have occurred due to an administration error on his part. Nevertheless, the Tribunal was satisfied that as regards the two instances on that date, 332 and 334 on Schedule 2, it was proved that they were procedures which had been recorded in his logbook and in which he had not been involved.

Dishonesty

86. At this point the Tribunal had established there was sufficient evidence to prove multiple examples as alleged within paragraphs 2(a) (b) and (c). The Tribunal also noted that as Dr Peters had conceded in his written and oral submissions that he applied what he now accepts was a flawed set of criteria when determining whether to record his involvement in a procedure as "S-TS", and regularly altered the patient number when recording more than one entry against a single patient, it is possible that more could be established. However, the Tribunal is only asked to determine whether there is evidence of "*more than one*" occasion and is satisfied that is sufficiently established. The Tribunal at this stage therefore commenced to determine the remaining paragraphs of the Allegation.

87. The Tribunal reminded itself of the test for dishonesty as set out in Ivey (above) when considering whether the incorrect recordings in the logbook by Dr Peters, as found proved, indicated that he was dishonest.

88. The Tribunal had been addressed by both parties as regards the impact or otherwise of Paragraph 1 of the Allegation on Dr Peters' good character. The Tribunal noted that although the warning was relatively recent, it could be considered minor in nature. The facts leading to the involvement of the police were quite specific and technical, with no factual dispute, Dr Peters had alerted the GMC but not other relevant bodies and the basis for the issuing of the warning had established there was no dishonesty involved. Neither party suggested it had potential relevance to propensity. The GMC submitted the warning was relevant as it indicated he had recently been reminded of the importance of full and correct submissions to the ARCP. The Tribunal noted that it could also in that regard be read as

supportive of a tendency towards a lack of care to detail; Dr Peters had accepted multiple times he was poor at administrative matters. The Tribunal determined that Dr Peters should be regarded as of effective good character, but that the circumstances of the warning may be of some relevance to their determination.

89. The Tribunal first considered whether it was credible that Dr Peters did not read or was unaware of the ISCP logbook guidance as regards when 'S-TS' code was appropriate. The Tribunal reminded itself of Dr Peters' evidence that he used 'the app' the majority of the time and not the website, and that the guidance was contained in the help function on the webpage and within an appendix of the ISCP curriculum. There was no evidence before the Tribunal that prior to the concerns being raised with him Dr Peters was ever specifically directed to the guidance or asked if he had read or was familiar with it. There were assumptions that Dr Peters would be aware of it including Ms A's evidence as training programme director that trainees would be aware of this from early stages of training. Mr C as Dr Peters' educational supervisor had the expectation that Dr Peters would have this knowledge at his stage of training. Mr C, in his witness statement, confirmed he did not provide a copy of the curriculum to Dr Peters as *"I would have expected him to have a clear understanding of it from his experience and the available resources."* In his witness statement Mr B stated that he was unsure whether Dr Peters was directly referred to the curriculum. Further, there was inconsistent evidence from the trainer consultants who provided evidence to this Tribunal as to the general level of understanding amongst other trainees of the guidance.

90. The Tribunal determined that at the relevant time there was a general assumption that trainees knew all relevant details of the curriculum. Ms A was quite clear that the onus was on the trainee surgeons and they would not be 'spoonfed'. The Tribunal noted that following her investigation into Dr Peters there was a recommendation from Dr D in the conclusion of her report that consideration be given to provide additional training for Trauma and Orthopaedic trainees and supervisors in London on logbook recording. The Tribunal also heard from Ms A that she had sent an email to all trainees to ensure that they did not have the same misunderstanding of the guidance that Dr Peters claimed. The email included the following,

> "*The ARCP panel will be running a training session during your training rotation day on Monday Oct 9th on logbook recording, where unbundling and other issues will be discussed in some detail we know it can be confusing."*

In addition to this training session the Tribunal was informed systems of annual quality assurance of a sample of logbooks and an induction for all trainees who would be specifically briefed on the curriculum when they are enrolled onto the training programme.

91. When asked about why this was done, Ms A initially responded that it was because she was aware that other trainees were not sufficiently appraised of the guidance, then changed her answer to say that it was solely due to the ignorance claimed by Dr Peters. The Tribunal find it unlikely that an extensive training exercise would be undertaken if the

Deanery and training programme directors were satisfied that only one individual was insufficiently knowledgeable.

92. The Tribunal noted that if Dr Peters had been dishonest then this dishonesty was always likely to be discovered, and that he would have been aware of this. The incorrect information in his logbook could have been identified at any number of opportunities. Dr Peters was required to submit his logbook for inspection at regular intervals and did so. Mr B in his statement records that he identified the 'red flag' which first alerted him while reviewing the summary sheet of the logbook. It did not require any investigation beyond reading the basic outlines of what Dr Peters had recorded, as Dr Peters would surely expect someone would do. What is more the 'red flag' case was one recorded during Dr Peters' time on the spinal unit which would have been 2018. The logbook had been submitted and used to assess Dr Peters' competency and experience several times since then with no challenge to it. In discussions with Dr D, Mr B says that '*the ratio was very odd'*. Again, this would have been discernible in any earlier reviews of the logbook.

93. Dr Peters informed the Tribunal that because he previously handed in his logbook to ARCP and had not been questioned, and had received satisfactory outcomes, it reinforced any belief he had that he was recording matters appropriately.

94. For the reasons set out above the Tribunal was not satisfied that the GMC had proved on the balance of probabilities that Dr Peters knew he was not the primary surgeon when he made the incorrect entries as regards Paragraph 2a, as required by Paragraph 4.

95. The Tribunal went on to consider the issue of dishonesty in relation to the matters found proved under paragraph 2b. It noted that Ms A told Dr D and repeated in cross examination, that trainees are not supposed to unbundle, and that the guidelines are relatively clear in that regard. She also went on to state to Dr D however that she '*recognises that some trainees do unbundle frequently and others don't*'.

96. For the Tribunal this was potentially indicative of a general concern which the Tribunal identified in the approach of some of those involved in the investigation into Dr Peters. The Tribunal offers no criticism, but it is relevant to the weight it gives to some elements of the evidence it has seen and heard. There does seem to be indications of early adoption of a conclusion as regards Dr Peters' intention by some involved in the investigation. Words such as 'dishonest' and 'fabricated' were employed from an early stage without recourse to explanation or further investigation which may have allayed some concerns. By way of example, Ms A refers in one instance dismissively to *'removing a bit of metal'* as wholly insufficient to merit an individual entry in the logbook. Very much to the contrary Mr C, who was the supervising surgeon for that operation, stated:

> *"60. The removal of metal was performed on three different anatomical regions, so this can be justified as three separate procedures in the logbook, in line with the ISCP guidelines. If Dr Peters has recorded in his e-logbook that he performed the procedure in one of these regions as the*

> *ST-S, I would have expected him to have been at this supervision level for at least one part of the operation.*
>
> *61. The only issue I see here is the incorrect use of hospital numbers as Dr Peters has recorded the operation under three different hospital numbers* – [XXX]. *I would have entered them all under the same hospital number and indicated in the notes that the cases were linked.*

97. In his interview with Dr D, Mr C states that he *'planned to go through the curriculum guidance again because they have updated the end criteria and has to doublecheck the unbundling rules to make sure he is doing it correctly*.' The Tribunal did not find this admission from a trainer and supervisor, who under the guidance is required to assist trainees in determining the extent of their involvement, as illustrative of the issue being 'relatively clear'. The Tribunal also noted that Mr C in the same interview with Dr D '*double checked on the surgical college website if he was JP's educational supervisor or clinical supervisor'.* Again, this is not to be critical of Mr C, but is perhaps indicative of the lack of rigour given to supervising and overseeing these matters.

98. The Tribunal noted the ARCP Panel Member interview meeting with Mr B in which he is recorded as having said,

> *"There is inevitably some unbundling that goes on purely because there are some operations which you cannot code together. He does not think other trainees change around a lot.* [Dr D] *asks if* [Mr B] *has seen this degree of unbundling before.* [Mr B] *responded by saying no, he's never come across a logbook which is so different to what he expected it to be for a trainee working in in that unit."*

This accorded with the written and oral evidence of Mr C in which he stated that he believed it was common practice for trainees to discuss informally what procedures could and could not be unbundled.

99. The Tribunal also reminded itself of findings of Dr D in her Investigation Report,

> *"I did not discover any evidence of wilful dishonesty…"*

This is in no way a binding finding on this Tribunal which must make its own conclusion on the basis of all the evidence. The Tribunal was not aware of the definition or test for dishonesty which had been applied by Dr D. However, it is of relevance. She referred to his actions as careless and naïve, but that she found his cooperation to be candid. This was her conclusion as the deputy Postgraduate Dean following an extensive investigation into the actions of Dr Peters including interviews with him, his supervisors and several other experienced consultants. It was also indicative of an acceptance on her behalf that there was scope for innocent mis-recording within the logbook system.

100. The Tribunal reminded itself of the witness statement of Ms A that,

> *"I consider these are minor issues because they are highly suggestive of sloppy recording, and not necessarily of fraud."*

Whilst this comment was offered in reference to the matters under paragraph 2c of the Allegation, they are nonetheless indicative of an awareness of a less than diligent approach to maintenance of the logbook.

101. The Tribunal noted also that there is no evidence that Dr Peters was ever challenged regarding his inclusion of injections in his logbook. The Tribunal was told these need not have been included and Dr Peters accepted that. He said he recorded them as evidence of his experience, which was the primary purpose of the logbook. He told the Tribunal that he believed that the logbook would automatically tally them as counting towards his target and he had to make manual adjustments to remove them. Despite that, there was no evidence he was ever challenged or told not to record them in the logbook.

102. The Tribunal did have concerns about Dr Peters' explanations in his response to the Allegation and his oral evidence. His inaccurate recording of the age of patients on some occasions was also troubling, though he did say this could have been as he entered the date of birth and the app then calculated age, so he could have incorrectly entered the relevant year. The Tribunal also considered that it was surprising that Dr Peters felt he had to adopt certain unorthodox workarounds to make his entries, but did not raise the issue. However, the Tribunal was also surprised that the GMC called no evidence as to how the app should be used and was used by others. The only evidence it had in this key regard came from Dr Peters.

103. The Tribunal reminded itself of the evidence of Mr E and Mr B in Dr D's interviews that they believed that some trainees regularly complete their logs quite late, making entries some time after the event.

104. Despite the concerns it had regarding the evidence of Dr Peters and the practices he said he adopted the Tribunal was of the view that these were suggestive of a reckless or careless approach to recording and did not support a finding of dishonesty. The Tribunal noted that Dr Peters was generally well regarded and had no previous record of dishonest behaviour. There was evidence, however, that Dr Peters did not take proper care with his administrative work. He has, throughout the investigation and this hearing, consistently maintained that the errors in the logbook were due to a genuine misunderstanding of what was required and poor practice in the recording.

105. For the reasons set out above, in particular the contrasting accounts supplied to the Tribunal as regards consistency of approach and understanding as to when 'unbundling' was permitted, the Tribunal finds that although Dr Peters was aware that he has was required to keep an accurate logbook and did make many incorrect entries as regards patient hospital numbers, he did not know at the relevant time that his logbook would give an inflated

impression of his surgical experience. Accordingly, Paragraph 5 of the allegation is not proved.

106. The Tribunal then went on to consider its findings as regards paragraph 2c, that on 2 occasions Dr Peters had made entries in relation to operations when he was not in any way involved and was in fact absent from the hospital due to XXX.

107. Dr Peters stated that these entries were due to carelessness and offered by way of explanation his practice of drafting entries prior or post to his involvement from schedules and records. He accepted he should have taken much more care when submitting the entry and apologised for the lapse.

108. The Tribunal was quite shocked on first consideration of this aspect of the Allegation, that a surgeon would record his involvement in operations when he was not even in the building. However, it was satisfied that the explanation supplied was in keeping with Dr Peters' general reckless approach to his records in his logbook. It also noted the comments of Ms A,

> *"I consider these are minor issues because they are highly suggestive of sloppy recording, and not necessarily of fraud."*

The Tribunal took her comment as some indication that a careless approach to the records, at least on the part of Dr Peters, was no surprise to her.

109. Accordingly, the Tribunal found that at the time he made the entries Dr Peters did not know that he had not been involved in the procedures and that his logbook would therefore give a false impression. For that reason Paragraph 6 is found not proved.

110. The Tribunal has determined the facts as follows:

That being registered under the Medical Act 1983 (as amended):

1. On 18 May 2021, you were given a Warning by the GMC as set out in Schedule 1 which was active until 18 May 2022. Admitted and found proved

2. In advance of your Annual Review of Competency Progression Panel ('ARCP') on 24 May 2023 (amended under Rule 17(6)), you completed and submitted your surgical training logbook ('logbook') and on one or more occasion in your logbook, as set out in Schedule 2 you:

    a. falsely recorded your role as Supervised - trainer scrubbed ('S-TS') in one or more surgical procedures ('procedures'); Determined and found proved

b. fabricated hospital numbers to record procedures that:

i. you had split up into single constituent parts from an operation involving a single patient ('unbundled'); Determined and found proved

ii. had not been performed on patients with the hospital numbers you recorded; Determined and found proved

c. falsely recorded your involvement in procedures which you had not been involved in. Determined and found proved

3. You knew that:

a. you were required to keep an accurate logbook; Admitted and found proved

b. the information included your logbook was untrue as you:

i. were not the primary surgeon for the procedures set out in paragraph 2a, having not performed the key components of the procedures; Determined and found not proved

ii. had fabricated hospital numbers as set out in paragraph 2b; Determined and found not proved

c. you had not been involved in the procedures recorded as set out in paragraph 2c; Determined and found not proved

d. your logbook would give the false impression that you had performed more procedures and gained more surgical experience than you had. Determined and found not proved

4. Your conduct at paragraph 2a was dishonest by reason of paragraph 3a, 3bi and 3d. Determined and found not proved

5. Your conduct at paragraph 2b was dishonest by reason of paragraph 3a, 3bii and 3d. Determined and found not proved

Your conduct at paragraph 2c was dishonest by reason of paragraph 3a, 3c and 3d. Determined and found not proved

And that by reason of the matters set out above your fitness to practise is impaired because of your misconduct. To be determined

Determination on Impairment - 02/07/2026

111. The Tribunal now had to decide in accordance with Rule 17(2)(l) of the Rules whether, on the basis of the facts which it has found proved and as set out, Dr Peters's fitness to practise is currently impaired by reason of misconduct.

The evidence

112. The Tribunal has reviewed its findings of fact and in addition, the Tribunal received further evidence as follows.

113. Dr Peters provided his own witness statement dated 23 June 2026 and the ARCP outcome dated 31 March 2026 and patient feedback.

114. The Tribunal also received in support of Dr Peters five testimonials from the following colleagues, all of which it has read:

- Mr F, Consultant Orthopaedic Surgeon dated 24 June 2026;
- Mr G, Consultant Orthopaedic Surgeon dated 22 June 2026;
- Mr H, Trauma and Orthopaedic Consultant and Dr Peters' clinical supervisor from October 2025 to April 2026 and Dr Peters' educational supervisor until October 2026, dated 19 June 2026;
- Professor I, Consultant Orthopaedic Surgeon dated 23 June 2026;
- Mr J, Trauma and Orthopaedic Consultant dated 10 February 2026.

Submissions

Submissions on behalf of the GMC

115. In his submissions Mr Grundy referred the Tribunal to the relevant paragraphs of the Guidance for MPTS Tribunals ('the Guidance') and paragraphs 19, 65 and 71 of Good Medical Practice ('GMP') 2006 – 2013, which was the current edition at the relevant time. He also reminded the Tribunal of its findings made at the facts stage of these proceedings.

116. Mr Grundy submitted that, whilst Dr Peters did not know at the time that his surgical logbook would give an incorrect impression of his surgical experience, it clearly did. Further, Mr Grundy submitted that by completing this false record of his experience in his surgical logbook Dr Peters potentially caused patient safety issues and adversely impacted public confidence and the maintenance of proper professional standards.

117. Mr Grundy stated that the Tribunal could find that a reckless approach to the completion of the surgical logbook raises issues of integrity, as opposed to dishonesty which it had ruled out in Stage 1. Mr Grundy reminded the Tribunal that, in his statement, Dr Peters

acknowledged that he did not take appropriate steps to ensure that his surgical logbook was correct.

118. Mr Grundy submitted that there was a serious departure from the standards set out in GMP and that this case falls at the higher end of the spectrum of seriousness. Mr Grundy reminded the Tribunal that Dr Peters was made subject to a formal warning in 2021 for similar issues of failing to take sufficient care in submitting information to the ARCP. Despite that warning there then followed these instances of reckless disregard of the need for accuracy in the completion of his surgical logbook.

119. Mr Grundy asked the Tribunal to consider how it could undermine public confidence in the profession if there was no finding of impairment in such circumstances, and reminded the Tribunal of the test as set out by *Dame Janet Smith's test in The Fifth Shipman Report,* as cited in *CHRE v NMC and P Grant [2011] EWHC 927 (Admin):*

> *a) Whether the registrant has in the past acted and/or is liable in the future to act so as to put a patient or patients at unwarranted risk of harm;*
>
> *b) Whether the registrant has in the past brought and/or is liable in the future to bring the profession into disrepute;*
>
> *c) Whether the registrant has in the past breached and/or is liable in the future to breach one of the fundamental tenets of the profession.*
>
> *d) Whether the registrant has in the past acted dishonestly and/or is liable to act dishonestly in the future.*

He also particularly referred the Tribunal to Paragraph 74 of that judgement which stressed the importance of recognising the impact of misconduct on the public interest limbs of the overarching objective:

> *74 In determining whether a practitioner's fitness to practise is impaired by reason of misconduct, the relevant panel should generally consider not only whether the practitioner continues to present a risk to members of the public in his or her current role, but also whether the need to uphold proper professional standards and public confidence in the profession would be undermined if a finding of impairment were not made in the particular circumstances.*

120. Mr Grundy submitted that it is proper and appropriate to find misconduct in this case and that Dr Peters' current fitness to practise is thereby impaired.

Submissions on behalf of Dr Peters

121. Mr Sutton also referred the Tribunal to the relevant paragraphs of the Guidance.

122. Mr Sutton submitted that it was for the Tribunal to consider whether poor or reckless recording within the logbook was a matter which is consonant with serious misconduct. He did concede that it was clear from the Tribunal's Determination that the conduct found proved did amount to a significant departure from the professional standards expected of a doctor as set out in Good Medical Practice. It was his submission however that Dr Peters was not currently impaired.

123. Mr Sutton submitted that it seems somewhat incongruous for the GMC to seek to inject the notion of a breach of 'integrity' into this issue despite the Tribunal's findings that there was no element of dishonesty. As regards the effect of the earlier written warning, Mr Sutton reminded the Tribunal that it had previously determined that Dr Peters should be regarded as of effective good character. He invited it to approach with a degree of scepticism the notion that this warning should now be seen as of particular consequence in its analysis at stage two, or should be seen to indicate in any way a lack of integrity on the part of Dr Peters.

124. Mr Sutton submitted that whilst there may be a significant departure from professional expectations in terms of record keeping, it is a departure that takes place in the context of a training environment, where the doctor's practice was overseen routinely by clinical supervisors, by an educational supervisor and by the programme director. Mr Sutton submitted that the checks and balances that should have been in place were not effective, and Dr Peters did not have the support that should have been afforded him.

125. Mr Sutton submitted that this is a case falling within the low end of the spectrum of seriousness. It involves erroneous record keeping in a logbook that Dr Peters considered was for his own use recording his own experience. It was not a hospital record and is not a record that had any patient implications and no consequent patient safety concerns.

126. Mr Sutton submitted that the working environment is highly significant in this case. He referred the Tribunal to its own findings as regards the shortfalls in oversight of Dr Peters and the inconsistencies in interpretation as to how the recording should take place within those responsible for this oversight.

127. Mr Sutton recognised that Dr Peters had acknowledged that the criticised entries were due to carelessness. Dr Peters also accepted he should have taken much more care when submitting the logbook and apologised for the lapse of care. Mr Sutton reminded the Tribunal of Dr Peters' immediate and ongoing engagement with the Deanery and the NHSE investigation, the GMC fitness to practise process and his candour with this Tribunal. Mr Sutton asked that the Tribunal accept that Dr Peters' participation has been characterised by cooperation and openness from the very outset. Mr Sutton submitted that there has since been a radical change in the way in which Dr Peters completes his logbook, including no longer using the app and engaging in a proactive discursive approach with his supervisors. Further, Mr Sutton advised that Dr Peters has reread GMP and familiarised himself with the standards set out there and has also read the curriculum.

128. Mr Sutton drew the Tribunal's attention to the comprehensive remedial steps that are evidenced in Dr Peters' reflective statements and strongly corroborated in the testimonial statements. Mr Sutton submitted that the Tribunal can safely conclude that the insight and remediation is such that there is no current impairment of Dr Peters' fitness to practise and no need for such a finding to be made.

The relevant legal principles

129. There is no burden or standard of proof at this stage of the proceedings and the decision of impairment is a matter for the Tribunal's judgment alone. The Tribunal will only make a finding of impairment where there is a legal basis for doing so and where a decision is reached that the doctor poses a current and ongoing risk to one or more of the three parts of public protection which is likely to require restrictive action in response. The three parts of public protection are to protect, promote and maintain the health, safety and well-being of the public; to promote and maintain public confidence in the profession; and to promote and maintain proper professional standards and conduct for members of the profession.

130. In approaching the decision, the Tribunal was mindful of the two-stage process to be adopted: first whether the facts as found proved amounted to misconduct, and that the misconduct was serious and then whether the finding of that misconduct which was serious could lead to a finding of impairment.

131. To assess whether Dr Peters poses any current and ongoing risk to public protection which may require restrictive action in response, the Tribunal will consider:

- where on the spectrum of seriousness the allegation lies, based on the facts found proved, the impact of any relevant context known about Dr Peters and/or their working environment, and
- how Dr Peters has responded to the allegations

The Tribunal's determination on impairment

Misconduct

Is there a legal basis for considering impairment?

132. The Tribunal first determined whether there was a legal basis for considering impairment. It was apparent that misconduct was the only potential basis. The Tribunal reminded itself of the facts of the case and the submissions of both parties.

133. The Tribunal also considered the test as set out in *Roylance v General Medical Council (No.2) [2000]1 AC 311 (UKPC)* which states:

> '*Misconduct is a word of general effect, involving some act or omission which falls short of what would be proper in the circumstances. The standard of propriety may often be found by reference to the rules and standards ordinarily required to be followed by a [medical] practitioner in the particular circumstances. The misconduct is qualified in two respects. First, it is qualified by the word professional which links the misconduct to the profession [of medicine]. Secondly, the misconduct is qualified by the word serious. It is not any professional misconduct which would qualify. The professional misconduct must be serious.'*

and *Nandi v General Medical Council [2004] EWHC 2317 (Admin) (04 October 2004):*

> *31 [misconduct is observed] as "a falling short by omission or commission of the standards of conduct expected among medical practitioners, and such falling short must be serious". The adjective "serious" must be given its proper weight, and in other contexts there has been reference to conduct which would be regarded as deplorable by fellow practitioners. It is of course possible for negligent conduct to amount to serious professional misconduct, but the negligence must be to a high degree.*

134. The Tribunal had regard to paragraph 19 of GMP as referred to by Mr Grundy in his submissions;

> *Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards*.

It also found paragraph 68 of GMP to be relevant and engaged;

> *You must be honest and trustworthy in all your communication with patients and colleagues. This means you must make clear the limits of your knowledge and make reasonable checks to make sure any information you give is accurate.*

135. In his statement dated 23 June 2026, Dr Peters wrote,

> *'I have realised that I ought to have been much more proactive in asking questions of my supervisors to ensure that my approach to logbook recording was correct ... I now fully appreciate that I had a duty positively to make enquiries of my trainers to ensure that I was doing things correctly and I recognise that I failed to do that. I realise the importance of the accuracy of a trainee's logbook given that its central role is to demonstrate the breadth and depth of experience necessary to become a consultant. … it was very foolish and unwise to change the details of a patient's hospital number. ... I deeply regret my approach and have learned lessons from it.'*

136. The logbook was a formal document designed to record Dr Peters' ability and experience, and as such a vital reference to inform the ARCP process. Dr Peters' failure to take appropriate care to keep an accurate record was a breach of professional standards as set out in GMP, as above.

137. The Tribunal reminded itself of its findings at the facts stage that

> *'…although Dr Peters was aware that he has was required to keep an accurate logbook and did make many incorrect entries as regards patient hospital numbers, he did not know at the relevant time that his logbook would give an inflated impression of his surgical experience.'*

However, the Tribunal also noted that it was

> *'…quite shocked on first consideration of this aspect of the Allegation, that a surgeon would record his involvement in operations when he was not even in the building.'*

138. Taking into account the identified breaches of GMP and the nature and extent of the misrecording, the Tribunal found that these failings constituted serious misconduct on the part of Dr Peters, thereby constituting a potential basis for impairment.

Where on the spectrum of seriousness does the allegation lie?

139. The Tribunal went on to consider where on the spectrum of seriousness the allegation lies.

140. The Tribunal determined that irrespective of any support to which he may have been entitled to expect, there was a responsibility on Dr Peters, as a trainee surgeon, to make himself aware of the requirements with which he was expected to comply. Whilst the facts found proved within the Allegation differ from the usual patient 'record keeping' issues, the Tribunal was satisfied that when considering the Guidance it should treat this matter as a 'clinical concern' as it relates to Dr Peters' professional performance. In reaching this decision the Tribunal was assisted by paragraph 164 of the Guidance:

> *164. Clinical concerns can include a wide range of matters relating to a doctor's behaviour and/or performance at work. A view will need to be reached about where on the spectrum of seriousness the concern or allegation lies with reference to the nature and extent of the departure from the professional standards and considering the presence of any features that increase seriousness*

141. The Tribunal also had regard to paragraph 28 of the Guidance which provides:

Allegations that usually fall at the lower end of the spectrum of seriousness and due to their nature are more likely to be easily remediable include, but are not limited to:

- *clinical failings, including where a doctor has acted without regard for patients' rights or feelings provided this is not a wilful disregard of their wishes*

142. The Tribunal also considered Paragraph 31 of the Guidance as regards Allegations that usually fall at the higher end of the spectrum of seriousness:

- *clinical failings that are not considered to be easily remediable, including those amounting to gross negligence or recklessness about a risk of serious harm to patients*

143. The Tribunal took into account the Guidance and all its knowledge of the nature and extent of the misconduct it had found established. It was satisfied that the nature of the misconduct was such that with proper application it was likely to be easily remediable. It was not indicative of lack of ability or knowledge or care towards patients, but rather of the want of greater diligence in recording his professional activities. The Tribunal determined that the starting point for assessing the level of seriousness of current and ongoing risk to public protection posed by Dr Peters was 'low'. It then went on to consider if there were any features which would increase that seriousness.

144. In his submissions, Mr Grundy stated that Dr Peters' behaviour was persistent or repeated. The Tribunal bore in mind the evidence given by Dr Peters at the facts stage that he did not know that what he was doing was wrong and that the errors in the logbook were due to a genuine misunderstanding of what was required. Further, Dr Peter's wrote in his statement,

'I have realised that I ought to have been much more proactive in asking questions of my supervisors to ensure that my approach to logbook recording was correct. I was wrongly reassured over the years by the fact that no issues were raised with me regarding my logbook entries.'

In such context the Tribunal was satisfied that the misconduct was better characterised as one continuing episode with repeated manifestations of this misunderstanding, rather than deliberate persistent or repeated behaviour.

145. The Tribunal considered whether Dr Peters had shown "*reckless disregard for patient safety or professional standards*." It determined that Dr Peters had displayed some reckless disregard for professional standards, though not patient safety. In his oral evidence given at the facts stage and in his written statement provided at the impairment stage, Dr Peters made clear that he believed that the logbook solely as a personal record with no relation to patient care. The Tribunal considered that Dr Peters was unaware at the material time of the

fact that he was making false entries, and of the potential importance of his training record, and did not consider any potential impact incorrect recording may have on his training or on those around him and their assessment of his level of competence.

146. The Tribunal was satisfied that Dr Peters' logbook was not intended to be used in any way relevant to patient care or part of a formal assessment of training and there is little to no element of risk to patient safety or to public protection. However, the Tribunal considered that there may be some risk to public confidence, through the fact of a doctor not keeping proper and accurate records. There was also the associated risk that he could be authorised to do operations for which he was not appropriately experienced due to the false entries. The Tribunal considered this a low risk as those supervising the doctor were aware of his actual skills and experience due to regular contact, and it was very quickly obvious to them that the logbook was inaccurate as soon as it was examined with any care. For these reasons the Tribunal did not consider this to be a factor which impacted its assessment of the seriousness of the misconduct.

147. The Tribunal determined that none of the features identified within the Guidance or apparent within the misconduct increases the level of seriousness identified in this case and the allegation remained at the lower end of the spectrum of seriousness.

<u>What is the impact of any relevant context known about Dr Peters and/or their working environment?</u>

148. In assessing the impact of any relevant context of Dr Peters' work environment, the Tribunal bore in mind the evidence received at the facts stage in particular,

- that there was a general assumption that trainees knew all relevant details of the curriculum, however, following the NHSE investigation, an induction process was subsequently implemented and provided to all trainees who would be specifically briefed on the curriculum when they are enrolled onto the training programme;
- the recommendation from Dr D that consideration be given to provide additional training for Trauma and Orthopaedic trainees and supervisors in London on logbook recording;
- That Ms A told Dr D that she '*recognises that some trainees do unbundle frequently and others don't*';
- the written and oral evidence of Mr C in which he stated that he believed it was common practice for trainees to discuss informally what procedures could and could not be unbundled;
- That Dr Peters was never challenged about the content of his logbook.

149. The Tribunal found these factors may indicate the required process was less 'clear cut' than was believed by some in positions of authority. The Tribunal particularly noted that once it became apparent that Dr Peters' logbook was inaccurate training for all staff and a new induction course were instituted. This was not consistent with Dr Peters being seen as a

sole outlier, but rather that there may be an issue with the guidance provided to him and others. In such circumstances this could be strong mitigation for the fact that Dr Peters' level of knowledge the procedures and actions expected of was not to the level it should be, though it would not absolve him entirely.

150. The Tribunal was satisfied that there was no personal context of relevance in this case, and none was advanced by the doctor.

How has Dr Peters responded to the allegations?

151. The Tribunal is satisfied that, through his reflective statement, Dr Peters has demonstrated that he now better understands the importance of the accuracy of his logbook. Dr Peters apologised and accepted that he should have been more proactive in asking questions of his supervisors. Dr Peters also wrote,

> *'I deeply regret my approach and have learned lessons from it. If I had raised the issue at the start, I could and would have corrected my practice immediately.*
>
> *…*
>
> *Since these issues were raised, I have fully acknowledged responsibility for my errors, and I have accepted the decisions of the ARCP Panels over the years, including when they have suggested extensions to my training.'*

152. Dr Peters is supported by the testimonials provided by people with a good, current and relevant knowledge of him, two of whom were on the ARCP panel which took place in May 2023. The Tribunal considered that these are testimonials that address the specific concerns raised in this case and carry considerable weight in its determination as to whether there are current concerns regarding Dr Peters' fitness to practise. No repeated inaccuracies of the number of procedures or supervision levels have been identified in the subsequent three years, and Dr Peters was noted to complete the logbook contemporaneously using the e-logbook website. Further, there are no concerns raised regarding Dr Peters clinical knowledge or skills.

153. The Tribunal noted that, in his testimonial statement, Mr F wrote,

> *'[Dr Peters] maintained a contemporaneous logbook that he uploaded mainly on the day of surgery directly onto the e-logbook website. At our initial educational meeting we agreed that at the start of each list and case we would discuss which cases were training and how these cases would be coded on the logbook (a technique I use for all trainees to avoid ambiguity). On occasions where I needed to contribute to the case surgically due to complexity [he] would ask about the surgeon level he could apply to his logbook.'*

154. The Tribunal considered that Dr Peters has fully cooperated with the Deanery investigation as well as the GMC investigation and the hearing process. Further, in his comments following the May 2023 ARCP, Dr Peters wrote that he respected the decision to send his logbook to the Deanery and, in his written statement he wrote that he accepted the decision to extend his training.

155.The Tribunal gave consideration to Paragraph 109 of the guidance,

> *109. Cases involving the following features can be more difficult to remediate:*
> *…*
>
> - *the nature of, or circumstances giving rise to, the allegation suggests there is an underlying issue with the doctor's attitude..*

The Tribunal bore in mind the misconduct when viewed in the context of the earlier formal warning could be seen to indicate an attitudinal problem towards compliance with processes. However, the Tribunal found more persuasive the significant evidence that Dr Peters has effected a real change in his approach to such matters.

156. In his testimonial, Professor I wrote,

> *…Mr Peters has discussed these issues openly and professionally with me. He has demonstrated a clear understanding that aspects of his previous logbook recording did not meet the standards expected of a surgical trainee and has expressed genuine regret that these inaccuracies occurred.*
>
> *…*
> *Since these matters arose, I have observed Mr Peters making considerable efforts to ensure that his documentation is accurate and contemporaneous. He has sought guidance regarding the appropriate recording of operative procedures, including the correct attribution of his role within operations and the circumstances in which procedures should be recorded within a surgical logbook.'*

157. In his personal statement, Dr Peters wrote

> *I hope to convey to the Panel that I am committed to learning from my errors and using this experience to confront and address my failings. It has certainly prompted me to adopt a tighter and more enquiring approach to my work and to engage closely with my trainers in a two-way and interactive relationship. I remain absolutely committed to achieving my Certificate of Completion of Training (CCT) (which is expected to take place in October 2026), for which the logbook is one of the assessment criteria; and to continuing to pursue a career*

as a trauma and orthopaedic surgeon. It is my sincere hope that I will be permitted to do this.

The Tribunal was satisfied that, had there been any attitudinal issues, the testimonials and other supporting evidence provided demonstrate that these have been addressed.

158. The Tribunal was satisfied that the evidence provided indicates full insight with strong and relevant remediation, and that there is little or no likelihood of the misconduct subject of these allegations being repeated. The Tribunal noted that Dr Peters is in any event near to the end of his training.

Tribunal's decision as to whether Dr Peters poses any current and ongoing risk to public protection which may require restrictive action in response and its finding on impairment

159. The Tribunal found that the allegation falls at the lower end of the spectrum of seriousness and that the issues specific to the allegations have been accepted and understood by Dr Peters and subsequently remediated with clear and comprehensive changes to behaviour and approach.

160. The Tribunal found that public confidence in the profession and professional standards will be maintained by recognition of Dr Peters comprehensive insight and remediation, as supported by the testimonials provided.

161. The Tribunal is further assured that any risk to public protection is also mitigated in that anyone fully acquainted with the circumstances of this case would be assured that it has been thoroughly investigated and examined by the regulatory authorities and that Dr Peters has fully engaged with this process.

162. The Tribunal has therefore determined that Dr Peters's fitness to practise is not currently impaired by reason of misconduct.

Determination on Warning - 02/07/2026

163. As the Tribunal determined that Dr Peters' fitness to practise was not impaired it considered whether in accordance with s35D(3) of the 1983 Act, a warning was required.

Submissions

164. Mr Grundy submitted that in these circumstances the GMC does not apply for a warning. Mr Grundy submitted that the GMC are conscious that warnings are issued in the interest of maintaining public confidence in the profession and upholding proper professional standards. Mr Grundy reminded the Tribunal that, although it made a finding of misconduct in this case, it also found that Dr Peters had full insight and had remediated. Mr Grundy further reminded the Tribunal of its finding there was little or no risk of repetition and that

public confidence in the profession and professional standards will be maintained by recognition of Dr Peters' comprehensive insight and remediation as supported by the testimonials provided. Taking into account the guidance, the GMC do not consider it appropriate or necessary to apply for a warning in this case.

165. Mr Sutton stated that unless the Tribunal wishes to hear from him, he had no submissions to make.

The Tribunal's determination on warning

166. The Tribunal has taken account of its earlier conclusions at the facts and impairment stages. It has also taken account of *Part D of Section three: MPT hearings of the Guidance for MPTS Tribunals* as to the purpose of warnings and the factors to be borne in mind when considering whether or not a warning is required.

167. To decide if a warning is required the Tribunal will first consider if there has been a clear and specific departure from the professional standards. If so, provided the allegation just fell short of the Tribunal finding that the doctor's fitness to practise is impaired, the Tribunal will go on to consider the question that if the behaviour or poor performance was repeated, would it likely result in a finding that the doctor's fitness to practise is impaired?

168. The Tribunal reminded itself of its findings at the impairment stage that Dr Peters had clearly breached paragraphs 19 and 68 of GMP. The Tribunal further reminded itself that it found that Dr Peters had been reckless rather than dishonest. Nevertheless, it had been satisfied that the misrecording had been such that it constituted serious misconduct and Dr Peters himself acknowledged that he should have taken more care.

169. When considering if the allegation of Dr Peters' behaviour just fell short of a finding of a finding that his fitness to practise is impaired the Tribunal was assisted by paragraph 23 of the Guidance;

> *If the MPT is satisfied that the evidence clearly supported a finding that the doctor's fitness to practise is not impaired, a warning will not be appropriate, and no further action should be taken*

170. The Tribunal considered that these events occurred in a specific training context that Dr Peters is unlikely to find himself in again. Dr Peters is supervised and monitored in his work and is due to finish his training in the next three months. Considering the Tribunal's finding on impairment for breaching professional standards Dr Peters has effected significant attitudinal and practice changes as evidenced in his written statement and the testimonials provided at the impairment stage. The Tribunal is satisfied that Dr Peters' insight is comprehensive and is validated by his consultant colleagues and educational supervisor. The Tribunal has been satisfied that the insight and remediate action was comprehensive and accordingly impairment was not a borderline issue.

171. The Tribunal determined that a reasonable and properly informed member of the public being aware of the steps that Dr Peters has taken to remediate would not be concerned if no warning were issued today. The Tribunal determined that the fact of the GMC investigation and these proceedings will act as a deterrent in itself.

172. In light of the Tribunal's findings regarding Dr Peters' insight and remediation it found that a warning would not be appropriate in this case and no further action should be taken.

173. Case concluded.

SCHEDULE 1

'On 25 August 2020 as part of your Annual Review of Competency Progression, you submitted a self-assessment document (Form R) to Health Education England North Central and East London in which you failed to disclose that since your last self-assessment you had been charged on 25 April 2020 with a criminal offence of failing to provide a specimen of breath for analysis and that you were subject to a GMC fitness to practise investigation.

On 8 September 2020 you were convicted of failing to provide a specimen of breath for analysis without reasonable excuse, when the police required the specimen to investigate a potential offence under the Road Traffic Act 1988.

This conduct does not meet with the standards required of a doctor. It risks bringing the profession into disrepute and it must not be repeated. The required standards are set out in Good medical practice and associated guidance. In this case, paragraphs 65 and 71 of Good medical practice are particularly relevant:

"65. You must make sure that your conduct justifies your patients' trust in you and the public's trust in the profession."

"71. You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading.

a You must take reasonable steps to check the information is correct.

b You must not deliberately leave out relevant information."

Whilst this failing in itself is not so serious as to require any restriction on your registration, it is necessary in response to issue this formal warning.

This warning will be published on the List of Registered Medical Practitioners (LRMP) in line with our publication and disclosure policy, which can be found at www.gmc-uk.org/disclosurepolicy.'

Schedule 2

Entry	Operation number	Date recorded in logbook	Correct date	Hospital number recorded in logbook	Correct hospital number	Operation Description recorded in logbook	Operation Description as per operation note	Supervision Code recorded in logbook	Dr Peters' Role as per operation note	Allegation Number
1	1	13/04/22		XXX	XXX	Tendon repair in foot	no record of patient and/or procedure	S-TS	N/A	2b
2		13/04/22		XXX	XXX	Tendon repair in foot	no record of patient and/or procedure	A	N/A	2b
3		13/04/22		XXX	XXX	Tendoachilles lengthening	no record of patient and/or procedure	A	N/A	2b
4		13/04/22		XXX	XXX	Tendoachilles repair	no record of patient and/or procedure	A	N/A	2b
5		13/04/22		XXX	XXX	Tendoachilles lengthening	no record of patient and/or procedure	A	N/A	2b
6		13/04/22		XXX	XXX	Tendoachilles repair	no record of patient and/or procedure	A	N/A	2b
17	2	20/04/22		XXX		Akin osteotomy of proximal phalanx great toe	Left Akin-type derotation and plantarflexion osteotomy	S-TS	Assistant	2a
18		20/04/22		XXX		Metatarsal fracture ORIF	no record of patient and/or procedure	S-TS	N/A	2a 2b
24	3	04/05/22		XXX		Removal metal	no record of patient and/or procedure	S-TS	N/A	2b
25		04/05/22		XXX		Fusion of MCPJ or IPJ	1. Left second toe proximal interphalangeal joint fusion (revision) 2.removal of screw left first MTPJ fusion	S-TS	Assistant	2a
29	4	11/05/22		XXX		EUA	Left 2nd – 5th TMT Joint Diagnostic and Therapeutic Injection Under Fluoroscopic Guidance	S-TS	Assistant	2a
30		11/05/22		XXX	XXX	Aspiration / injection foot joint	no record of patient and/or procedure	S-TS	N/A	2a

42	5	01/06/22		XXX	XXX	Lesser toe tenotomy	No record of patient and/or procedure	S-TS	N/A	2a 2b
43		01/06/22		XXX	XXX	Lesser toe tenotomy	No record of patient and/or procedure	S-TS	N/A	2a 2b
44		01/06/22		XXX		Tendon transfer foot	Right Tibialis Posterior Tendon Transfer + 2nd to 5th Toe Flexor Tenotomies	S-TS	Assistant	2a
49	6	06/07/22		XXX		Primary ankle arthroplasty	Right Infinity Total Ankle Replacement with Prophecy Custom Instrumentation	S-TS	Assistant	2a
57	7	13/07/22		XXX	XXX	Botulinum toxin injection -musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
58		13/07/22		XXX	XXX	Botulinum toxin injection -musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
59		13/07/22		XXX		Botulinum toxin injection -musculoskeletal	Right Lower Limb Botox Injections – Tib Post FHL FDL Gastroc (x2) + Moulded POP	S-TS	None recorded (Dr wrote Op note)	2a
60		13/07/22		XXX	XXX	Botulinum toxin injection -musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
61	8	20/07/22		XXX		Tendoachilles repair	Left Achilles Tendon speedbridge and removal of bony spur	S-TS	Assistant	2a
71	9	24/08/22		XXX		Primary ankle arthroplasty	Left Infinity Total Ankle Replacement with Prophecy Custom Instrumentation	S-TS	2nd Surgeon	2a

72	10	24/08/22		XXX		EUA	Bilateral MTP Joint Diagnostic and Therapeutic Injection and Manipulation	S-TS	Assistant	2a
73		24/08/22		XXX	XXX	MUA joint not listed elsewhere	no record of patient and/or procedure	S-TS	N/A	2a 2b
74		24/08/22		XXX	XXX	EUA	no record of patient and/or procedure	S-TS	N/A	2a 2b
75		24/08/22		XXX	XXX	MUA joint not listed elsewhere	no record of patient and/or procedure	A	N/A	2b
76		24/08/22		XXX	XXX	Aspiration / injection foot joint	no record of patient and/or procedure	A	N/A	2b
77		24/08/22		XXX	XXX	Aspiration / injection foot joint	no record of patient and/or procedure	A	N/A	2b
82	11	02/09/22		XXX		First MTPJ arthrodesis	Right 1st MTPJ arthrodesis + 2-5 metatarsal head excisions + 2nd pipj fusion + 3-5 osteoclasis	S-TS	Assistant	2a
83		02/09/22		XXX	XXX	Minimally invasive lesser metatarsal osteotomy	no record of patient and/or procedure	S-TS	N/A	2a 2b
84		02/09/22		XXX	XXX	Forefoot arthroplasty (Mann Thompson /Stainsby / Other	no record of patient and/or procedure	S-TS	N/A	2a 2b
85		02/09/22		XXX	XXX	Lesser metatarsal osteotomy - distal	no record of patient and/or procedure	S-TS	N/A	2a 2b
86		02/09/22		XXX	XXX	Fusion of MCPJ or IPJ	no record of patient and/or procedure	S-TS	N/A	2a 2b
87		02/09/22		XXX	XXX	Fusion of MCPJ or IPJ	no record of patient and/or procedure	S-TS	N/A	2a 2b
88		02/09/22		XXX	XXX	Minimally invasive lesser metatarsal	no record of patient and/or procedure	S-TS	N/A	2a

						osteotomy				2b
89		02/09/22		XXX	XXX	Minimally invasive lesser metatarsal osteotomy	no record of patient and/or procedure	S-TS	N/A	2a 2b
90		02/09/22		XXX	XXX	Fusion of MCPJ or IPJ	no record of patient and/or procedure	S-TS	N/A	2a 2b
91		02/09/22		XXX	XXX	Fusion of MCPJ or IPJ	no record of patient and/or procedure	S-TS	N/A	2a 2b
92		02/09/22		XXX	XXX	First MTPJ arthrodesis	no record of patient and/or procedure	S-TS	N/A	2a 2b
93		02/09/22		XXX	XXX	Forefoot arthroplasty (Mann Thompson /Stainsby / Other	no record of patient and/or procedure	S-TS	N/A	2a 2b
107	**12**	28/09/22		XXX		Tibio-talo-calcaneal arthrodesis /calcaneal-talo-tibial arthrodesis	Left Tibiotalocalcaneal Joint Arthrodesis using OxBridge Nail	S-TS	Assistant	2a
110	**13**	06/10/22		XXX		EUA	Procedure; B/L Hip Arthrogram -f left Pembersal osteotomy	A	N/A	2c
111		06/10/22		XXX		Osteotomy hip - pelvic for DDH	no record of patient and/or procedure	A	N/A	2c
112		06/10/22		XXX	XXX	Hip spica application	no record of patient and/or procedure	A	N/A	2b
113		06/10/22		XXX	XXX	Arthrogram hip	no record of patient and/or procedure	A	N/A	2b
114		06/10/22		XXX	XXX	Osteotomy hip - pelvic for DDH	no record of patient and/or procedure	A	N/A	2b
123	**14**	06/10/22		XXX		Removal metal	Removal of metal work - left pelvis (1x 6.0mm cannulated screw 2x 4.5mm cortical screw).	S-TS	3rd Surgeon	2a

124		06/10/22		XXX		Removal metal	Removal of metal work - left pelvis (1x 6.0mm cannulated screw 2x 4.5mm cortical screw).	S-TS	3rd Surgeon	2a
125		06/10/22		XXX	XXX	Removal metal	no record of patient and/or procedure	A	N/A	2b
126		06/10/22		XXX		EUA	no record of patient and/or procedure	S-TS	N/A	2a
127	**16**	12/10/22		XXX		Percutaneous tendo-achilles release for CTEV	Right Tendo-achilles Tenotomy + Penseti Casting	S-TS	Assistant	2a
128	**15**	12/10/22		XXX		Osteotomy not listed elsewhere	Right Midfoot Osteotomy (Cuboid closing medial cuneiform opening) + Tibialis Anterior Transfer	S-TS	Assistant	2a
130	**17**	13/10/22		XXX	XXX	Arthrogram hip	no record of patient and/or procedure	S-TS	N/A	2a 2b
131		13/10/22		XXX		EUA	Lower limb examination under anaesthetic; right muscle release- hip medial including adductor longus adductor brevis lengthening and gracilis; right osteotomy femur proximal varus derotational osteotomy; right hip arthrogram; osteotomy pelvis; right gastric fascial lengthening and application of plaster cast; application of long leg traction.	S-TS	3rd Surgeon	2a
132		13/10/22		XXX	7406035	Adductor tenotomy - hip	no record of patient and/or procedure	S-TS	N/A	2a 2c
133		13/10/22		XXX	7406035	Osteotomy hip	no record of patient and/or procedure	S-TS	N/A	2a 2b
134		13/10/22		XXX	7406035	Tendoachilles lengthening	no record of patient and/or procedure	S-TS	N/A	2a

										2b
135		13/10/22		XXX	XXX	Botulinum toxin injection musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
137	**18**	18/10/22		XXX		EUA	EUA Pelvic X-ray Botulinum Toxin to B/L hamstrings. Right hip adductor and B/L calves	S-TS	2nd Surgeon	2a
138		18/10/22		XXX	XXX	Botulinum toxin injection musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
139		18/10/22		XXX	XXX	Botulinum toxin injection musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
140		18/10/22		XXX	XXX	Botulinum toxin injection musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
141		18/10/22		XXX	XXX	Botulinum toxin injection musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
142		18/10/22		XXX		EUA	EUA Botulinum Toxin to B/L hamstrings. Right calf and right tib post	S-TS	2nd Surgeon	2a
143		18/10/22		XXX	XXX	Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
144		18/10/22		XXX	XXX	Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
145		18/10/22		XXX	XXX	Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
146		18/10/22		XXX		EUA	EUA Botulinum Toxin to B/L hamstrings	S-TS	2nd Surgeon	2a
147		18/10/22		XXX		Tendon release or lengthening	no record of patient and/or procedure	S-TS	N/A	2a

										2b
148		18/10/22		XXX		Tendon transfer foot	no record of patient and/or procedure	S-TS	N/A	2a 2b
149		18/10/22		XXX		Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
150		18/10/22		XXX		Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
151		18/10/22		XXX		EUA	Botulinum Toxin to left calf and left pronator teres	S-TS	Assistant	2a
152		18/10/22	29/11/22	XXX		Iliac crest bone graft harvesting	Bilateral removal of calcaneal Steinmann pins + botulinum toxin to bilateral hip adductors + bilateral hamstrings	S-TS	Assistant	2a
153		18/10/22		XXX		Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
154		18/10/22		XXX		Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
155	**19**	20/10/22		XXX	XXX	Hamstring lengthening	no record of patient and/or procedure	S-TS	N/A	2a 2b
156		20/10/22		XXX	XXX	Adductor tenotomy	no record of patient and/or procedure	S-TS	N/A	2a 2b
157		20/10/22		XXX		Hamstring lengthening	Bilateral hamstring lengthening and adductor release	S-TS	3rd Surgeon	2a
158		20/10/22		XXX	XXX	Adductor tenotomy	no record of patient and/or procedure	S-TS	N/A	2a 2b

159		20/10/22		XXX	XXX	EUA	no record of patient and/or procedure	S-TS	N/A	2a 2b
171	**20**	27/10/22		XXX	XXX	Arthrogram hip	no record of patient and/or procedure	S-TS	N/A	2a 2b
172		27/10/22		XXX	XXX	Osteotomy hip	no record of patient and/or procedure	S-TS	N/A	2a 2b
173		27/10/22		XXX	XXX	Open reduction for DDH	no record of patient and/or procedure	S-TS	N/A	2a 2b
174		27/10/22		XXX	XXX	Osteotoy hip-pelvic for DDH	no record of patient and/or procedure	S-TS	N/A	2a 2b
175		27/10/22		XXX	XXX	Hip Spica application	no record of patient and/or procedure	S-TS	N/A	2a 2b
176		27/10/22		XXX		EUA	Left Hip EUA + dynamic arthrogram + Shortening de-rotation Varus Periarticular Femoral osteotomy + Periacetabular pelvic osteotomy -f Broomstick cast	S-TS	N/A	2a
181	**21**	1/11/22		XXX	XXX	Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
182		1/11/22		XXX	XXX	Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
183		1/11/22		XXX	XXX	Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b

184		1/11/22		XXX		EUA	Botulinum Toxin to left hamstrings + left gastrocnemius	S-TS	Assistant	2a
185		1/11/22		XXX	XXX	Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
189	**22**	9/11/22		XXX		Through knee amputation	Right through knee amputation and retention of patella	S-TS	Assistant	2a
190		9/11/22		XXX		Osteotomy not listed elsewhere	Right distal tibia + fibula supramalleolar osteotomy	S-TS	Assistant	2a
191		9/11/22		XXX	XXX	Osteotomy not listed elsewhere	no record of patient and/or procedure	S-TS	N/A	2a 2b
192	**23**	15/11/22		XXX	XXX	Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
193		15/11/22		XXX	XXX	Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
194		15/11/22		XXX	XXX	Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
195		15/11/22		XXX		EUA	Botulinum Toxin to right flexor carpi ulnaris + flexor carpi radialis + right gastrocnemius	S-TS	Assistant	2a
196		15/11/22		XXX	XXX	Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
198		15/11/22		XXX		Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	P	N/A	2b
199		15/11/22		XXX		Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	P	N/A	2b
200		15/11/22		XXX		Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	P	N/A	2b

201		15/11/22		XXX		Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	P	N/A	2b
206	**24**	17/11/22		XXX	XXX	EUA	no record of patient and/or procedure	S-TS	N/A	2a 2b
207		17/11/22		XXX	XXX	Adductor tenotomy - hip	no record of patient and/or procedure	S-TS	N/A	2a 2b
208		17/11/22		XXX	XXX	Osteotomy hip - proximal femoral for DDH	no record of patient and/or procedure	S-TS	N/A	2a 2b
209		17/11/22		XXX	XXX	Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
210		17/11/22		XXX	XXX	Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
211		17/11/22		XXX		EAU	Right hip EUA and arthrogram right hip open reduction adductor tenotomy proximal femoral osteotomy and dega pelvic osteotomy	S-TS	Assistant	2a
215	**25**	24/11/22		XXX	XXX	Adductor tenotomy - hip	no record of patient and/or procedure	S-TS	N/A	2a 2b
216		24/11/22		XXX	XXX	Osteotomy hip - pelvic for DDH	no record of patient and/or procedure	S-TS	N/A	2a 2b
220	**26**	29/11/22		XXX		EUA	no record of patient and/or procedure	S-TS	N/A	2a 2b
221		29/11/22		XXX		Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a

										2b
222		29/11/22		XXX		EUA	no record of patient and/or procedure	S-TS	N/A	2a 2b
223		29/11/22		XXX		Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
224		29/11/22		XXX		Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
225		29/11/22		XXX		Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
226		29/11/22		XXX		Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
227		29/11/22		XXX		Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
228		29/11/22		XXX		EUA	no record of patient and/or procedure	S-TS	N/A	2a 2b
229		29/11/22		XXX		Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
230		29/11/22		XXX		Removal metal	no record of patient and/or procedure	S-TS	N/A	2a 2b
231	**27**	1/12/22		XXX	XXX	Osteotomy hip - proximal femoral for DDH	no record of patient and/or procedure	S-TS	N/A	2a 2b
232		1/12/22		XXX		EUA	no record of patient and/or procedure	S-TS	N/A	2a 2b

233	**28**	1/12/22		XXX	XXX	Arthrogram hip	no record of patient and/or procedure	S-TS	N/A	2a 2b
234		1/12/22		XXX		EUA	Right hip Planning arthogram EUA and injection	S-TS	N/A	2a
235		1/12/22		XXX	XXX	Aspiration / injection hip joint	no record of patient and/or procedure	S-TS	N/A	2a 2b
238	**29**	14/12/22		XXX		Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
239		14/12/22		XXX		Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
240		14/12/22		XXX		Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
241		14/12/22		XXX		Botulinum toxin injection - musculoskeletal	no record of patient and/or procedure	S-TS	N/A	2a 2b
242		14/12/22		XXX		EUA	no record of patient and/or procedure	S-TS	N/A	2a 2b
253	**31**	30/12/22		XXX	XXX	Lesser toe tenotomy	no record of patient and/or procedure	A	N/A	2b
254		30/12/22		XXX	XXX	Hamstring lengthening	no record of patient and/or procedure	S-TS	N/A	2a 2b
255		30/12/22		XXX	XXX	Hamstring lengthening	no record of patient and/or procedure	S-TS	N/A	2a 2b

256		30/12/22		XXX		Hamstring lengthening	B/L Hamstring lengthening Gastroc Lengthening Tibialis anterior lengthening Right FHL lengthening Botox to B/L Hamstrings Gastroc and Tibialis posterior	S-TS	2nd surgeon	2a
257		30/12/22		XXX	XXX	Tendoachilles lengthening	no record of patient and/or procedure	S-TS	N/A	2a 2b
258		30/12/22		XXX	XXX	Lesser toe tenotomy	no record of patient and/or procedure	S-TS	N/A	2a 2b
259		30/12/22		XXX	XXX	Hamstring lengthening	no record of patient and/or procedure	A	N/A	2b
260		30/12/22		XXX	XXX	Hamstring lengthening	no record of patient and/or procedure	A	N/A	2b
261		30/12/22		XXX	XXX	Tendoachilles lengthening	no record of patient and/or procedure	A	N/A	2b
262		30/12/22		XXX	XXX	Lesser toe tenotomy	no record of patient and/or procedure	A	N/A	2b
268	**30**	30/12/22		XXX	XXX	Exostosis / osteochondroma excision	Excision of osteochondroma Left distal femur	S-TS	N/A	2a 2b
270	**32**	05/01/23		XXX	XXX	Arthrogram hip	no record of patient and/or procedure	S-TS	N/A	2a 2b
271		05/01/23		XXX	XXX	Osteotomy pelvis - not for DDH	no record of patient and/or procedure	S-TS	N/A	2a 2b
272		05/01/23		XXX	XXX	Adductor tenotomy - hip	no record of patient and/or procedure	S-TS	N/A	2a 2b
273		05/01/23		XXX	XXX	Open reduction for DDH	no record of patient and/or procedure	S-TS	N/A	2a 2b
274		05/01/23		XXX	XXX	Osteotomy hip - proximal femoral for DDH	no record of patient and/or procedure	S-TS	N/A	2a

										2b
275		05/01/23		XXX		EUA	Right adductor release open hip reduction proximal femoral shortening varus osteotomy + fixation pelvic Dega osteotomy	S-TS	3rd Surgeon	2a
282	**34**	25/01/23		XXX		Arthroscopy knee other therapeutic S-TS Elective procedure	Symptomatic right knee. Lateral meniscus posterior horn radial tear + partially discoid menisus (MRI)	S-TS	3rd Surgeon	2a
283		25/01/23		XXX	XXX	Arthroscopy knee diagnostic	no record of patient and/or procedure	S-TS	N/A	2a 2b
285	**33**	09/02/22		XXX	XXX	EUA	no record of patient and/or procedure	S-TS	N/A	2a 2b
286		09/02/23		XXX	XXX	Arthrogram hip	no record of patient and/or procedure	S-TS	N/A	2a 2b
287		09/02/23		XXX	XXX	Arthrogram hip	no record of patient and/or procedure	S-TS	N/A	2a 2b
288		09/02/23		XXX	XXX	Aspiration / injection hip joint	no record of patient and/or procedure	S-TS	N/A	2a 2b
289		09/02/23		XXX		Aspiration / injection hip joint	no record of patient and/or procedure	S-TS	N/A	2a 2b
290		09/02/23		XXX		EUA	Bilateral hip Examination Under Anaesthesia + Arthrogram + LA/Steroid injection	S-TS	2nd Surgeon	2a

301	**35**	21/2/23		XXX		Removal external fixator or frame	Removal of external fixator left tibia	S-TS	N/A	2a
311	**36**	23/2/23		XXX		Removal of hardware and revision fixation	Reinsertion of proximal and distal locking screws to right femoral retrograde fitbone insertion of proximal one third tubular plate to maintain screw position	S-TU	3rd Surgeon	2a
312	**37**	27/2/23		XXX	XXX	EUA	No record of patient and/or procedure	S-TS	N/A	2a 2b
313		27/2/23		XXX		Patella fracture ORIF (not tension band wire)	Left knee patellar stabilisation (EUA excision of small fragment of nonunited bone from patella with medial reefing of retinaculum and MPFL)	S-TS	A	2a
325	**38**	07/03/23		XXX		Removal metal	Left proximal tibia removal of locking screws	S-TS	Assistant	2a
327		07/03/23		XXX		Benign tumour excision (not exostosis	No record of patient and/or procedure	S-TS	N/A	2a 2b
328	**39**	08/03/23		XXX		Lesser metatarsal osteotomy	Left foot fifth metatarsal Chevron osteotomy and excision of lateral eminence	S-TS	Assistant	2a
329		08/03/23		XXX	XXX	Metatarsal fracture ORIF	No record of patient and/or procedure	S-TS	N/A	2A 2b
330		08/03/23	19/04/23	XXX		Tendoachilles repair	Bilateral tendo-achilles lengthening plus plantar fascia release plus casting for afo	S-TS	N/A	2a

							plus application of below-knee plaster of Paris			
343	**40**	27/03/23		XXX	XXX	Benign tumour excision (not exostosis	No record of patient and/or procedure	A	N/A	2b
344		28/03/23		XXX		Diaphyseal femur fracture plate/screw fixation	No record of patient and/or procedure	A	N/A	2b

Allegation 2c cases

21		20/04/22		XXX		Aspiration / injection foot joint	Left sinus tarsi Diagnostic and Therapeutic injection	A	N/A	2c
110	**13**	06/10/22		XXX		EUA	Procedure; B/L Hip Arthrogram -f left Pembersal osteotomy	A	N/A	2c
111		06/10/22		XXX		Osteotomy hip - pelvic for DDH	no record of patient and/or procedure	A	N/A	2c
132		13/10/22		XXX	XXX	Adductor tenotomy - hip	no record of patient and/or procedure	S-TS	N/A	2a 2c
160		20/10/22		XXX		Tendoachilles lengthening	Right tendo-achilles HOKE lengthening	A	N/A	2c
169		21/10/22		XXX	XXX	Percutaneous tendo-achilles release CTEV	Percutaneous Bilateral TA tenotomies under LA	O	N/A	2c

170		21/10/22		XXX	XXX	Percutaneous tendo-achilles release CTEV	Percutaneous Bilateral TA tenotomies under LA	O	N/A	2c
332		09/03/23		XXX		DIaphyseal tibial fracture circular frame	Application of taylor spatial frame to right tibia for deformity correction and traction lengthening of bone	A	N/A	2c
334		09/03/23		XXX		Removal metal	Removal of right femoral intramedullary nail	A	N/A	2c